

Increasing Access to Services Provided through Indian Health Services Subcommittee

Meeting Notes 10/21/2015

Attendees: Jerilyn Church, Great Plains Tribal Chairman's Health Board; Kim Malsam-Rysdon, Governor's Office; Stephanie Denning, HMA; Lynne Valenti, DSS; Jason Dilges, Governor's Budget Office; Kathaleen Bad Moccasin, IHS; Brenda Tidball-Zeltinger, DSS; Senator Troy Heinert, Mission; Tim Trithart, Community Health Center of Black Hills; Justin Taylor, Flandreau Tribal Administrator; Bryan Slaba, Wagner Community Hospital; Rachael Sherard, Avera; Monica Huber, Sanford; Angelia Svihovec, Mobridge Hospital; Scott Duke, SD Association of Health Care Organizations; Sonia Weston, Oglala Sioux Tribal Council; Richard Huff, IHS; Charlene Red Thunder, Cheyenne River Sioux Tribal Health Consultant; Mike Diedrich, Regional Health; Dr. Tad Jacobs; Avera; Terry Dosch, Council of Community Mental Health Centers; Willie Bear Shield, Rosebud Sioux Tribe; Evelyn Espinoza, Rosebud Sioux Tribe; Sonny Colombe, Great Plains Tribal Chairman's Health Board; Gilbert Johnson, SD Association of Healthcare Organizations; Sara DeCoteau, Sisseton Tribal Health Director

Opening

Stephanie Denning opened the meeting and noted the revised agenda. Kim Malsam-Rysdon reviewed the goal of this subcommittee which is to increase access to services provided by Indian Health Service (IHS) and Tribal Health programs. She recapped the two areas of focus identified at the subcommittee meeting on 10/7/15: increasing access through, 1) the use of Tele-Health, and 2) making more specialty services available.

Improving Access - Ideas from Providers

There were five proposals on ways to help increase access to services through partnerships with IHS/Tribal Health Organizations that were submitted to the subcommittee from providers: three from Avera, one from Sanford and one from the Community Health Centers of SD. Kim Malsam-Rysdon asked that representatives from each group present a brief overview of their proposals for the group.

Monica Huber from Sanford described their One Connect telemedicine program that offers support for emergency department providers. The Virtual Consults telemedicine program supports access to sub-specialty care; the E-Visits program address some limited primary care needs and Video Visits enable providers to communicate directly with patients at their homes or other locations to address certain acute, non-emergent primary care needs. All of these programs are in use in a variety of locations and have demonstrated successful cost-savings as well as high provider and patient satisfaction.

Tim Trithart shared that the Community Health Centers' proposal was focused on increasing access to the 100% federal funding for primary care through partnerships between IHS and Federally Qualified Health Centers (FQHCs); for example, credentialing FQHCs as IHS providers, aligning prescription access between FQHCs and IHS/Tribal Health Organizations, and expanding telemedicine opportunities between FQHCs and IHS/Tribal Health Organizations.

Rachel Sherard from Avera Health introduced Avera's eEmergency Care – quick access to high quality care for providers in ERs that may not have full staffs of specialists or may want/need additional physician consult support for certain cases. She also talked about ePharmacy, which offers 24/7 pharmacist support for hospital-based patients. Dr. Jacobs added that ePharmacy was very helpful with formulary alignment differences from the hospital to other providers. Avera has an eConsult telemedicine program similar to Sanford's that could provide IHS and Tribal Health Organizations access to specialists. Rachel explained that Avera does have a telemedicine relationship with an IHS clinic in Lame Deer, MT, which is in another IHS region; but they have been able to work through a lot of the IHS EMR issues with them to get this up and running.

Kim Malsam-Rysdon noted that the New Services Subcommittee would be looking specifically at Medication Therapy Management as one option and asked if the ePharmacy could potentially be helpful in those issues. Dr. Jacobs said it currently is designed specifically for an inpatient hospital setting, but they could look at how to modify it to potentially fit into an outpatient setting as part of a coordinated care approach. This idea will be communicated to the New Services Subcommittee for them to pursue.

Each of the providers has multiple access points for their telemedicine services, but they are not necessarily located in Indian Country. The group discussed if it is possible to take space within a non-Tribal provider's facility and designate it as IHS/Tribal so Tribal members could come there for certain kinds of care and be eligible for the 100% FMAP. That is a part of the specific request to CMS that we are waiting for further guidance on. As part of the overall review they are doing of the 100% FMAP options, CMS also is looking at the contractual requirements between IHS/Tribal Health Organizations and non-IHS/Tribal providers, as well as additional care coordination requirements. The request to CMS also considers 100% federal funding for services provided through Urban Indian Health centers.

Dr. Jacobs noted that Avera does have the ability to provide contracted coordinated care services, and that might be an additional model to consider. They have care teams that coordinate around diabetic education, training and support, medication management, and other health needs. It is similar to the Health Home model. Avera will provide further information about this service.

Mike Diedrich said that while Regional had not submitted any formal ideas to the Access Subcommittee, he did have ideas about opportunities and things that they have been exploring to help increase access to needed care for Native Americans in their community. For example, they have explored leasing IHS space in their facility; it is complicated, and there are a lot of rules, but it is doable. Another idea would be whether IHS would allow Tribal members access to urgent care instead of the ER. Regional has ER to ER protocols and has invited IHS providers to training and classes where they can get free CME credits. Regional also has the ability to initiate tele-health visits.

The group determined that telemedicine support for emergency room providers clearly met a critical need and there was a lot of evidence about its effectiveness, as well as information about how to implement the service.

There also was a discussion about OB/GYN care and whether that was one specialty area that providers could support with telehealth options. IHS and Tribal representatives confirmed that OB/GYN care is a big need and having telehealth available to support care in the local hospitals and service areas would be helpful. The group also discussed some of the barriers to accessing care for pregnant women with

substance abuse issues. There may be ways to use additional access to telemedicine to support offering these women more options for help to address both their addictions and their prenatal care needs.

Another area of need is for general surgery. Some of the IHS/Tribal Health Organizations have the facilities and equipment but don't have the providers. There may be opportunities to have providers rotate through areas and bring patients in to the IHS/Tribal Health Organizations on those days to access surgical services. However, this requires a heavier "lift" to make work. Additionally, there are contracting issues, as well as IHS credentialing requirements that present challenges. However, there was agreement that it is something worth pursuing even if it would be a longer-term opportunity to realize the benefits. This relates somewhat to the specialty consults via telemedicine, which providers said they do today.

The non-IHS providers felt that providing specialty consults via telemedicine would be easier to implement in the short term, and that the group should prioritize this for increasing access to care. Monica Huber explained that scheduling specialty consults using telemedicine does not necessarily require a critical mass of patients needing a specific kind of specialty care for it to work. Consults with various types of specialists can occur on the same day as long as there is acceptable facilitation of appointments at the originating site.

The subcommittee agreed to focus on the following priority areas:

1. E-Emergency Care at IHS facilities
2. OB/GYN/prenatal care
3. Specialty Consults via telemedicine
4. General surgery at IHS facilities

Providers will rework their proposals in these areas to include more details. They will try to include more information to match what IHS looks for in its contracting and request for proposals process. Each of the providers also noted that there are some minimum requirements to making telemedicine ideas work – for example, the data lines and equipment, staff resources to manage the consults and maintain equipment, etc. They will include this kind of information in their proposals.

Barriers to Innovation at IHS and Tribal Health Organizations

Tribal representatives all expressed that it is really important that the Tribes understand how this effort will benefit them and their members. They need to see that the State and IHS are serious about making improvements and increasing access to services for Native Americans. For example, how will it help the 30-year-old who injures his shoulder and can't work, but doesn't have access to anything but his local service site, which can't do the surgery he needs and can't pay for him to get it somewhere else. He then can't work and in a specific case ended up with an addition to pain medication that all could have been prevented if he had been able to get his shoulder fixed in the first place.

The group discussed that increasing the FMAP to 100% can help to fund expansion increasing both access and services to Native Americans. Expansion will make more Native Americans eligible for Medicaid – just like the example given of the young man with the injured shoulder. Increasing access to Medicaid also helps IHS and Tribal Health Organizations because they can bill Medicaid for services for those patients instead of using their IHS funds to pay for the care. It can help local service sites "stretch"

their IHS dollars farther because they are able to bill more through Medicaid. It will be very important to ensure that this message gets out to the Tribes and their members so they can see the real benefits.

Several of the Tribal representatives noted that there still seem to be a lot of barriers to making changes and doing innovative things at the IHS service sites. They would like to better understand IHS policies and contracting processes, so they know how to navigate through the system and can identify ways to avoid bottlenecks or things that will automatically slow the process. There is a difference between things that are in federal statute and things that are administrative rules, so a better understanding of the barriers and being able to identify which could be changed more easily through administrative rules vs. through advocating for statutory change would be helpful and could move some things more quickly.

There should and could be other ways to improve access to care through IHS and Tribal Health Organizations. The Rosebud Sioux Tribe has been working on creating local health boards and developing partnerships and contracts with other local providers to supplement the services they can provide. For example, a question was asked about how the University of South Dakota Medical School was supporting IHS and Tribal Health Organizations with medical residents and fellows. There are a lot of challenges currently to these kinds of partnerships.

Several of the Tribal representatives said that they encounter barriers with IHS and don't always understand why they cannot get approval to move forward on some of their innovative ideas regarding improvements to access and helping to build and enhance the health services and supports their members need. The point also was made that IHS cannot qualify for federal grants for things like telehealth equipment; however, the Tribes can, and there should be ways for the Tribes to help get dollars to support things like building telehealth infrastructure, or getting equipment for local service sites.

An issue was raised about primary care provider designations and getting reimbursed for care when a Tribal member sees a provider that is not their assigned PCP. Brenda Tidball-Zeltinger noted that there are currently processes in place with Medicaid to allow for referrals and that this should be an issue that could be easily fixed. She noted she would follow up after the meeting to see how to help get it resolved.

Jerilyn Church noted that The Tribal Chairman's Health Board has a budget consultation meeting scheduled with the Great Plains Regional IHS Office on November 10. That meeting will include time for other items and would be a good opportunity to formally raise some of these issues. She asked if the Tribal representatives could put together some specific issues and barriers they would like to see addressed so she can have something concrete to present at that Consultation meeting.

IHS Contracting Issues

IHS Contracting is problematic and complicated. Richard Huff explained that there currently is an RFP on the FedBizopps website (<https://www.fbo.gov/>) for a contract to provide Emergency Department staffing at the Winnebago service site. This RFP would be a good example of the kind of information IHS looks for in an RFP and contract, such as a Scope of Work, Quality Assurance Plan, etc. Obviously, the contractor has to meet all the requirements, and there are issues related to things like kickback rules. Sometimes those rules end up being counter-productive to achieving the end goal, and they can discourage some providers and contractors from bidding, so it is important to understand them going in.

There was a question about the IHS credentialing process, and whether there is an expedited process of licensure/credentialing. Richard Huff explained that credentialing is done for each service site separately, but all has to go up through a regional review. It is a very cumbersome and time-consuming process for providers and for IHS.

Review of data requested at October 7th Meeting

There was one question about the data provided after the last meeting, related to the IHS referral data and whether it was only for referred patients who didn't get the care for which they were referred, or was for something else. Kathaleen confirmed it was for patients who were referred and did not get the care.

The group requested IHS identify the amount of increased revenue it would receive if the state expanded Medicaid to cover adults up to 138% of the federal poverty level.

Kathaleen Bad Moccasin reminded the group that there is a difference between Direct Care and Purchased/Referred Care (PRC), which creates issues around payment and could complicate all the different discussions about improving access. Per the IHS website on Purchased/Referred Care (formerly known as Contract Health Services, <http://www.ihs.gov/chs/>):

"Medical/dental care provided at an IHS or tribal health care facility is called Direct Care. The CHS Program [PRC] is for medical/dental care provided away from an IHS or tribal health care facility. CHS [PRC] is not an entitlement program and an IHS referral does not imply the care will be paid. If IHS is requested to pay, then a patient must meet the residency requirements, notification requirements, medical priority, and use of alternate resources."

"Indian descendants residing off the reservation may be eligible [for PRC] if they meet certain conditions. If not residing on the reservation such individuals must live within the CHSDA and (1) be members of the tribe(s) located on the associated reservation or (2) "maintain close economic and social ties with that tribe or tribes."

"Each visit to a non-IHS health care provider and the associated medical bill is distinct and must be examined individually to determine CHS [PRC] eligibility. All CHS [PRC] requirements must be met for each episode (treatment) of care. A patient must meet residency, notification, the medical priority of care and use of alternate resources requirements in order to be eligible for CHS [PRC]. Example: If a CHS [PRC] authorization is issued, IHS will pay the first medical treatment. Follow up care or additional medical care are to be done at the nearest accessible IHS or tribal facility, or will require approval with a new CHS [PRC] authorization. If this process is not followed, the patient may be responsible for the expense."

This issue could potentially be mitigated if the current proposal for creating a single CHSDA across both North and South Dakota were moved forward and implemented.

Next Steps

- Follow-up between Medicaid and specific Tribal representative regarding the issue of PCP assignment and payment for care. (Brenda Tidball-Zeltinger)

- Subcommittee leaders will move the ePharmacy discussion to the New Services Subcommittee. (To be presented at the first New Services Subcommittee meeting)
- Providers to submit updated proposals related specifically to telehealth support for EDs, OB/GYN supports, specialist consults through telehealth, and general surgery access. They will include information about the minimum level of technology and resources that would be needed from IHS/Tribal Health Organizations to support their proposals. (Due by October 30)

Tribal representatives will collaborate with IHS to compile a list of the common issues they encounter when trying expedite contractual arrangements or when trying to develop new or innovative approaches to increase access to services at their local service site. The topics can addressed during the Tribal Chairman's Health Board Consultation with IHS on November 10. (Due by November 6)

Next Meeting

Wednesday, November 4, 3 – 5 p.m., Ramkota, Gallery D